



Testimony

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MEDICARE

HCFA Oversight Allows Contractor Improprieties to Continue Undetected

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G A O

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Medicare: HCFA Oversight Allows Contractor Improprieties to Continue Undetected

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss HCFA's efforts to monitor the activities of Medicare fee-for-service claims administration contractors. These contractors pay more than \$700 million in Medicare claims each business day on behalf of the Health Care Financing Administration (HCFA)—the primary steward of Medicare funds. HCFA paid these contractors \$1.6 billion in fiscal year 1998 to serve as Medicare's first line of defense against inappropriate and fraudulent claims. Findings of inappropriate Medicare payments to providers totaling billions of dollars each year have heightened concerns about the program's management. Cases in which contractors themselves have engaged in improper activities and even defrauded Medicare dramatically compound the concerns.

Our testimony today will expand on the testimony we provided to this Subcommittee this past July.¹ Specifically, we will discuss how deceptive activities became a way of doing business at some of HCFA's Medicare fee-for-service contractors; the details of Medicare contractor improprieties for which there have been criminal convictions, fines, or civil settlements; and the effect of these activities on the Medicare program.² We will also discuss why HCFA did not detect these activities through its oversight. Finally, based on the findings of our report on HCFA's oversight of its claims administration contractors, we will describe weaknesses in HCFA's current monitoring process that could allow these types of activities to recur without detection.³

In brief, following allegations that they engaged in fraudulent or otherwise improper activities, at least eight Medicare contractors have been convicted of criminal offenses, have been fined, or have entered into civil settlements since 1993. Over several years, some of these contractors' employees engaged in improprieties and covered up poor performance to allow contractors to keep their Medicare business. Admitted or alleged improper activities included, but were not limited to, improperly screening, processing, and paying Medicare claims; destroying claims; and failing to properly collect money owed to Medicare by providers. In

¹Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors (GAO/T-HEHS-99-167, July 14, 1999).

²Medicare: Improprieties by Contractors Compromised Medicare Program Integrity (GAO/OSI-99-7, July 14, 1999).

³Medicare Contractors: Despite its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115, July 14, 1999).

addition, contractors falsified their performance results and engaged in activities designed to deceive HCFA and circumvent its review of contractor performance. These fraudulent and improper activities have adversely affected taxpayers, providers, and beneficiaries. Because HCFA gave contractors too much advance notice of its oversight visits and the records that would be reviewed, it often failed to detect improper contractor activities. HCFA's current oversight has other weaknesses that might allow the same types of improper contractor activities to continue undetected.

Background

To illustrate the significance of the contractors' improprieties, I will first explain briefly what the insurance companies are required to do while processing claims and how HCFA determines whether the companies meet those requirements.

Under their contracts with HCFA, Medicare contractors are required to process claims in accordance with HCFA guidelines and report their performance accurately to HCFA. The contractors are required to, among other activities, (1) properly screen and process claims to ensure that the claims are eligible for Medicare payment and that Medicare pays the correct amount; (2) process claims in a timely manner; (3) answer beneficiary and provider telephone calls in a timely fashion; (4) provide samples of claims, provider audit files, and related workpapers to HCFA; and (5) accurately report claims processing and payment errors to HCFA.

During the 1980s and through fiscal year 1994, HCFA evaluated contractor performance through its Contractor Performance Evaluation Program (CPEP). During CPEP audits, HCFA examined sample files from various contractor units to score functions performed by each unit. HCFA used CPEP scores in several ways—for example, to determine whether contracts should be renewed, and sometimes to award incentive payments to contractors. HCFA terminated CPEP in 1994 because it found that contractors strove merely to maximize CPEP scores rather than improve their overall performance, and several contractors provided false information to HCFA to achieve higher CPEP scores. In fiscal year 1995, HCFA replaced CPEP with the Contractor Performance Evaluation, or CPE. The CPE process allows HCFA's reviewers discretion to evaluate any contractor activity, including claims processing, customer service, payment safeguards, fiscal responsibility, and administrative activities.

Contractors Deceived HCFA Concerning Their Poor Performance

As we reported on July 14, 1999,⁴ since 1993, criminal or civil actions have been taken against at least six Medicare contractors because of their performance. The criminal actions generally involved conspiracy, obstruction of federal audits, and false statements. The civil actions involved settlements related to qui tam⁵ complaints filed by contractor employees in which the federal government intervened. Over \$235 million in civil and criminal fines have been assessed against those six contractors.⁶ On July 28, 1999, the Justice Department announced that two additional contractors⁷ and a related company that the contractors jointly owned⁸ have pleaded guilty to criminal felony counts related to their Medicare business. Similar to the cases we discussed in our July reports and testimony, the two Medicare contractors and the related company pleaded guilty to conspiracy to obstruct a federal audit after admitting they concealed evidence of poor performance from federal auditors. In addition, the two contractors pleaded guilty to attempting to obstruct a federal audit. The three companies agreed to pay a total of \$1.5 million in criminal fines to the government. Also, the two Medicare contractors have entered into a civil settlement of nearly \$12 million.

Our report on contractor improprieties focused primarily on three contractors—Blue Cross Blue Shield (BCBS) of Illinois, Blue Shield of California, and BCBS of Michigan. In all these cases, the contractors entered into civil settlements and, in two, contractors pleaded guilty to multiple counts of criminal fraud.

Employees at all levels of those contractors—including vice-presidents for Medicare operations, their directors of operations, managers, supervisors, and staff-level employees—had engaged, or were alleged to have engaged, in fraudulent and other improper activities for prolonged periods of time. These employees failed to properly conduct claims processing and safeguard activities and then covered up their poor performance by

⁴GAO/OSI-99-7, July 14, 1999.

⁵Qui tam suits are filed under the False Claims Act, 31 U.S.C. sections 3729-3733. The act's qui tam provisions permit filers, often referred to as "relators" or whistleblowers, to share in financial recoveries resulting from their cases.

⁶In addition to the \$235 million recovered from these companies as civil settlements and criminal fines and penalties in civil and criminal fraud cases, at least three of these companies have also entered into settlements in civil liability cases brought by HCFA for recovery of about an additional \$30 million owed to Medicare under the Medicare Secondary Payer program.

⁷Rocky Mountain Hospital and Medical Service (doing business as Blue Cross and Blue Shield of Colorado) and New Mexico Blue Cross and Blue Shield, Inc.

⁸Rocky Mountain Health Care Corporation.

doctoring records that HCFA staff reviewed. The employees did so because they feared losing their Medicare contracts and their jobs if they did not meet HCFA's expectations. Investigators and former contractor employees told us that manipulating samples, covering up errors, and "fixing" HCFA-selected records before HCFA's review became a way of life at each of the three contractors. Indeed, the contractors allegedly designed the activities to deceive HCFA by creating the false appearance that they were meeting HCFA's criteria. According to three former contractor employees and investigators in two of the cases, such activities spread as employees at various levels and units taught each other how to commit improprieties.

Improper Contractor Activities Hid Poor Performance

Our report presents a number of examples of criminal and other improper activities that contractors allegedly or admittedly engaged in to deceive HCFA. In the three cases on which we focused, federal investigators documented many of the activities alleged by the qui tam whistleblowers. The five general categories of alleged improper activities illustrated by the following examples were related to us by federal investigators, qui tam whistleblowers and other former contractor employees, and one whistleblower's attorney, or were described in qui tam complaints, plea agreements, or other public documents:

- Improperly screening, processing, and paying Medicare claims. In an effort to receive the maximum payment by maximizing the number of claims processed, Blue Shield of California, according to the investigating agent, rushed claims through the processing system, shutting off computer edits designed to catch problem claims. Blue Shield of California, according to the qui tam whistleblower, also paid claims without proper physician signatures or backup documentation.
- Improperly destroying or deleting claims. In order to eliminate backlogs of unprocessed claims, BCBS of Illinois allegedly deleted some claims that contained incomplete or incorrect information by using special computer coding. Claimants were not notified that these claims would not be paid nor told what information was needed to correctly process their claims and then given an opportunity to provide it.
- Failing to collect Medicare overpayments and interest, as required. While not admitting to wrongdoing, BCBS of Michigan settled a civil suit for \$27.6 million. Among the allegations in that suit was that, from 1988 through 1993, BCBS of Michigan circumvented a requirement to collect provider overpayments within 30 days of the overpayment determination date by making it appear that payments were collected on time when, in

fact, they were not. As a result, the contractor allegedly did not assess interest on the overpayments as required.

- Falsifying documentation and reports to HCFA regarding performance. BCBS of Illinois and Blue Shield of California admitted in their plea agreements with the government that they had falsified reports on which CPEP and CPE performance evaluations were based in order to make their performance appear acceptable to HCFA. These reports included information about claims processing errors, claims processing timeliness, and timely contractor response to incoming customer telephone calls.
- Improperly altering or hiding files that involved incorrectly processed or paid claims and inadequately performed contractor audits of Medicare providers prior to HCFA's review of such files. Blue Shield of California improperly fixed claims that had been processed incorrectly and were to be reviewed by HCFA. It did so, for example, by (1) stamping "signature on file" on claims that had been paid without a signature; (2) detaching documents, such as another insurance company's Explanation of Benefits, from improperly denied Medicare Secondary Payer claims⁹ to give the appearance that the denials were correct; and (3) altering procedure codes to make it appear that claims had been paid properly when they had not. The whistleblower in the BCBS of Michigan case alleged that this contractor, prior to HCFA's review, redid original audit workpapers, improperly altered audit records, did required audit work that had not been completed, and obtained new information from providers that should have been collected in the original audit. In some cases, according to the whistleblower, the contractor steered HCFA away from problem audits by lying about their status if the audits could not be adequately "fixed" in time for HCFA's review.

Improprieties Harm the Medicare Program, Its Providers, and Beneficiaries

Medicare pays claims incorrectly when contractors improperly turn off edits; fail to properly develop, process, or audit claims; or improperly deny or delete claims. This can lead to additional costs to the Medicare program. When contractors use evasive means to make it appear that overpayments are collected on time, Medicare suffers not only from the untimely repayment of such overpayments but also from the lost interest that should have been assessed on overdue overpayments.

Customer service is also affected by improper contractor activities. Providers and beneficiaries are forced to resubmit claims that are improperly destroyed, deleted, or denied. This causes delays in payment,

⁹Medicare is the secondary payer on claims involving beneficiaries who are also covered by Black Lung, Veterans Health Administration, or employer-sponsored group health plans.

unnecessary duplication of effort, and additional administrative costs to Medicare claimants. When claims are denied or deleted without the claimants being notified of any underlying problems with the claims, the claimants may file replacement claims containing the same mistakes.

Providing HCFA with false work-processing samples relative to their performance under Medicare contracts resulted in contractors receiving scores that were too high, leading to the false appearance of superior performance. This allowed Medicare contractors to retain their contracts even when their performance was deficient. BCBS of Illinois received over \$1 million in incentive payments as a result of its offenses.

In addition, providing false information led HCFA to make a poor management decision in reassigning claims administration workload. In 1994, HCFA awarded BCBS of Illinois the intermediary and carrier contracts for the state of Michigan, after alleged contractor improprieties by BCBS of Michigan were revealed. In a March 1994 announcement of this workload transfer, a former HCFA Administrator was quoted as saying, apparently based on HCFA evaluations tainted by the contractor's deceptive activities, that the Health Care Service Corporation (BCBS of Illinois) "has a record of outstanding performance in administering the Medicare program in Illinois." He was also quoted as saying that "the selection of Health Care Service Corporation as the replacement contractor was based on a record of integrity, cost-effective performance, claims-processing efficiency, ability to assume the workload, and experience." In 1998, BCBS of Illinois pleaded guilty to improprieties similar to those allegedly committed by BCBS of Michigan.

Why HCFA Did Not Detect Improprieties

HCFA did not detect fraudulent and improper activities in the three cases we reviewed in depth until former contractor employees brought them to light by filing *qui tam* complaints under the False Claims Act. The individuals we interviewed—including federal investigators, *qui tam* whistleblowers, and other former employees—gave the following reasons why HCFA did not detect contractor improprieties:

- HCFA notified contractors in advance concerning (1) the dates on which it would conduct CPEP reviews and (2) the specific or probable records that it would review. This gave contractors the time and opportunity to manipulate samples and hide problems. HCFA officials sometimes had contractors pull the records to be reviewed and relied on contractor-provided documents that consisted largely of copies, not

originals. Document copies could be, and were, altered and recopied without detection.

- Contractors allegedly circumvented HCFA's review of their performance and deceived HCFA about their efficiency in customer service. For example, a former employee of BCBS of Illinois told us that he tracked HCFA's periodic, unannounced telephone calls, which HCFA had designed to check the contractor's response time. In doing so, he identified HCFA's calling pattern. The unit manager then used that pattern to circumvent HCFA's review by putting extra employees on the telephone lines during the anticipated times until they received HCFA's call.
- Contractors also allegedly deviated from their normal procedures to deceive HCFA. For example, according to former contractor employees, BCBS of Illinois reassigned its two most experienced employees to conduct claim reviews that occurred on the days that HCFA had scheduled for review. Contractor managers instructed these employees to slow down the review process and take their time to ensure that the reviews were done with 100-percent accuracy and included proper documentation.

Problems Could Be Continuing Under HCFA's Current Oversight Process

The fraud alleged in integrity cases such as those we have described today began when CPEP was HCFA's primary means of assessing contractors—from fiscal years 1980 to 1995. In some cases, the fraud continued under HCFA's current CPE oversight process. The CPE process has a number of weaknesses that continue to make the program vulnerable to contractor fraud. HCFA places too much trust in its contractors by relying on contractor self-certifications of management controls and contractors' self-reported performance data—both of which it rarely checks. Further, HCFA currently has few standards to measure contractors' performance. Until recently, it had not set evaluation priorities for its regional review staff and still does not check on the quality of regional oversight to ensure that HCFA staff are held accountable for providing adequate oversight. Important program safeguards have received little scrutiny at some contractors, and regional staffs have been inconsistent in dealing with contractor performance problems.

HCFA Seldom Validates Contractors' Internal Controls or Workload Data

Medicare contractors are required to certify annually that they have established a system of internal management controls over all aspects of their operations. This helps ensure that they meet program objectives, comply with laws and regulations, and are able to provide HCFA with reliable financial and management information concerning their operations. However, we found that HCFA accepts Medicare contractors'

self-certification of management controls without routinely checking that the controls are working as intended. In April 1998, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) reported that the regional offices were not evaluating the accuracy and reliability of contractor internal control certifications. In response, HCFA headquarters sent guidance to the regional offices reminding them to validate contractors' self-reports during the 1998 evaluation review cycle. Our analysis of fiscal year 1998 reviews performed for seven contractors found no case in which a self-report was validated. We believe systematic validations of contractor internal controls would contribute significantly to reducing the likelihood of contractor fraud.

An equally fundamental activity in overseeing contractor performance is obtaining reasonable assurance that self-reported contractor performance data are accurate. HCFA, however, has largely relied on unvalidated contractor-submitted data to evaluate and monitor performance. We analyzed 170 reports related to contractor performance for fiscal years 1995 through 1997 for the seven contracts we studied; only two of these reports documented efforts to validate contractor-supplied performance data. For 1998, staff in one of the three regions we visited validated contractor data in five reports. Staffs of the other two regions did not validate any performance data over the 4-year period for the contractors we examined.

HCFA Sets Few Performance Standards for Contractors

Except for standards mandated by legislation, regulation, or judicial decision, HCFA's current CPE process is more descriptive than evaluative. There are only a few mandated standards, such as processing claims within specific time periods. No standards require HCFA reviewers to ensure that contractors adequately perform the most important program safeguards—such as medical review of claims. There are few performance standards to motivate contractors and no benchmarks for HCFA to use in holding contractors accountable.

Even where statute or regulation requires HCFA to follow clearly defined and measurable standards, we found that HCFA has not held its reviewers accountable for checking contractor performance for these standards. Reviewers have not always evaluated whether contractors met the mandated standards even when the reviewers were required to do so. Our analysis of CPE reports for three regional offices found that when HCFA reviewers assessed claims processing activities, for example, they only checked contractor compliance with about half of the applicable

mandated standards. Furthermore, the three regions varied considerably in their performance of this requirement, with one region checking less than 15 percent of the standards, while another region checked over 80 percent.

HCFA Regions Provide Uneven and Inconsistent Reviews and Remedies

With limited headquarters guidance and little follow-up to ensure that what guidance there is is followed, contractor oversight is highly variable across regions. Without a set of common performance standards or measures, reviewers and contractors lack clear expectations. This has resulted in both uneven review of critical program safeguards—such as checking how effective contractors are at identifying insurers primary to Medicare—and inconsistencies in how HCFA reviewers handle contractor performance problems. Uneven review continues to leave HCFA unable to discriminate among contractors' performance when it needs to reassign workload.

One such critical program safeguard where oversight has been limited and uneven is that of Medicare Secondary Payer—so-called MSP activities. Contractor MSP activities seek to identify insurers that should pay claims mistakenly billed to Medicare and to recover payments made by Medicare that should have been paid by others. This program safeguard has saved about \$3 billion annually from 1994 through 1998. Our review of three regions' CPE reports shows that many of the key MSP activities most germane to spotting claims covered by MSP provisions were not reviewed at the seven contractors in our study. Also, the three regions varied considerably in how often they reviewed MSP, with one region rarely checking MSP activities at any of its contractors whose CPES we reviewed.

The low level of review is particularly disturbing because the potential for contractor fraud regarding MSP activities is significant as a result of an inherent conflict of interest: the private insurance business of the contractor can be the primary payer for some claims subject to the MSP provisions. HCFA has had to pursue several insurance companies—including some with related corporations that serve as Medicare contractors—in federal court for refusing to pay before Medicare when Medicare should have been the secondary payer. In such a case filed by HCFA against BCBS of Michigan, the company agreed to a \$24 million settlement. Since 1995, almost \$66 million in settlements have been made in cases filed by HCFA in which a health insurance company with private policies that were sometimes primary to Medicare was also a Medicare carrier or intermediary. HCFA currently has filed an additional

\$98 million in claims against companies affiliated with current and former contractors.

We also found that HCFA's regions differ in their identification of contractor problems and took dissimilar actions once a performance problem was identified. For example, one region required Contractor A to take steps to address deficiencies in its performance in fraud and abuse prevention and detection. In contrast, another region, reviewing Contractor B, found many more serious weaknesses with its fraud and abuse prevention and detection activities. Contractor B was spending little or no time actively detecting fraud and abuse, failed to use data to detect possible fraud, failed to adequately develop large and complex cases, and was not referring cases to the HHS OIG. Furthermore, Contractor B was performing poorly in recovering overpayments, had not focused on the highest-priority cases, prepared no fraud alerts, and was not suspending payments to questionable providers. The reviewer concluded that Contractor B failed to meet HCFA's performance expectations, yet the region did not even require the contractor to develop and follow improvement plans. Because HCFA reviewers are not held accountable for conducting adequate oversight, deficient contractor performance can continue.

HCFA Has Started to Develop a More Structured Evaluation Process

HCFA has recognized that its oversight of contractors has been inadequate and issued guidance in fiscal year 1998 to have regional reviewers follow a somewhat more structured evaluation process. In May 1998, citing concerns raised by the HHS OIG and us regarding HCFA's level of contractor oversight, HCFA announced the "need to reengineer our current contractor monitoring and evaluation approach and develop a strategy demonstrating stronger commitment to this effort." As a result, HCFA issued a contractor performance evaluation plan specifying three evaluation priorities for fiscal year 1998: year 2000 computer compliance activities, activities focusing on a subset of financial management operations (accounts receivable and payable), and activities focusing on a subset of medical review activities.

In 1998, HCFA also emphasized the need for regions to follow its structured CPE report format, including clearly stating whether the contractor complied with HCFA's performance requirements. In addition, the regions were supposed to review certain activities at all contractors. Nonetheless, we found that some of the 1998 reviews continued to lack a structured format, making it difficult to compare contractor performance. Although

regions were supposed to review contractors' determinations of medical necessity prior to payment, we found that two of the regions we reviewed did not do so for all of the seven contractors included in our study. Plans for this year's CPE reviews include more central office involvement in the assessment process, joint review teams from headquarters and the regions, and multi-regional team reviews.

HCFA Lacks a Structure That Assures Accountability

HCFA's organizational structure is not designed to ensure oversight accountability, with two aspects creating particular problems. First, HCFA reorganized its headquarters operations in 1997, dispersing responsibility for contractor activities from one headquarters component to seven. This functional dispersion was, in part, in response to concern that one office should not oversee all contractor activities. Second, HCFA's 10 regional offices—the front line for overseeing contractors—do not have a direct reporting relationship to headquarters units responsible for contractor performance. Instead, they report to the HCFA Administrator through their respective regional administrators and consortia directors.

In our July 1999 report, we found that these two aspects of reorganization—dispersion of responsibility for contractor activities to multiple headquarters components and regional office reporting relationships—contribute to communications problems with contractors, exacerbate the weaknesses of HCFA's oversight process, and blur accountability for (1) requiring regions to adopt best practices; (2) routinely evaluating the regional offices' performance of their oversight; and (3) enforcing minimum standards for conducting oversight activities, including taking action when a particular region may not be performing well in overseeing contractors. In an effort to establish more consistency and improve the quality of contractor management and oversight, HCFA has recently modified its organizational structure once again by consolidating responsibility for contractor management within the agency and creating a high-level contractor oversight board. It is too early, however, to tell how effective these changes will be in improving accountability for ensuring sufficient and consistent contractor oversight.

GAO's Previous Recommendations to the Administrator

To improve HCFA's oversight of contractors, we made five recommendations to the Administrator in our July 14, 1999, report:

1. Establish a contractor management policy that requires (a) verification that all contractors have effective internal controls, and (b) systematic

validation of statistically significant samples of essential contractor-reported data.

2. Improve annual contractor assessments by:

- developing a comprehensive set of clearly defined and measurable performance standards, including measures for program safeguard activities;
- assessing all contractors regularly on core performance standards and reviewing individual contractors on other activities identified by risk assessments; and
- developing an annual report for each contractor that includes performance on the core standards and other HCFA-assessed standards, using a uniform format that permits comparisons among contractors and longitudinal assessments of individual contractors.

3. Designate a HCFA unit to be responsible for:

- evaluating the effectiveness of contractor oversight policy and direction from headquarters to regional offices;
- evaluating regional office contractor oversight based on the headquarters' policy and direction; and
- enforcing minimum oversight standards.

4. Ensure that all relevant HCFA staff learns about contractor problems and best practices and that HCFA reviewers adopt best oversight practices.

5. Develop a strategic plan for managing Medicare's claims administration contractors.

In written comments to a draft of our report, HCFA agreed with each of our recommendations and described how it plans to implement them. Overall, we believe that HCFA is planning to take a number of steps in response to these recommendations that—if properly designed and implemented—should help improve its management and oversight of Medicare's claims administration contractors. While we do not believe that implementation of these recommendations will guarantee that contractors will no longer have integrity problems in their dealings with HCFA, we do believe that it will make the Medicare program less vulnerable to the types of abuses that have been described here today.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions you or other Members of the Subcommittee may have.

GAO Contacts and Acknowledgment

For future contacts regarding this testimony, please contact Leslie G. Aronovitz at (312) 220-7600 or Robert Hast at (202) 512-7455. Individuals who made key contributions to this testimony included Sheila Avruch, Mary Balberchak, Elizabeth Bradley, Stephen Iannucci, Bob Lappi, Don Walthall, and Don Wheeler.

GAO Related Products

Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors ([GAO/T-HEHS/OSI-99-167](#), July 14, 1999)

Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity ([GAO/HEHS-99-115](#), July 14, 1999)

Medicare: Improprieties by Contractors Compromised Medicare Program Integrity ([GAO/OSI-99-7](#), July 14, 1999).

HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century ([GAO/T-HEHS-99-58](#), Feb. 11, 1999).

Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy ([GAO/AIMD-98-284](#), Sept. 28, 1998).

Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities ([GAO/HEHS-98-160](#), June 1, 1998).

Medicare: Control Over Fraud and Abuse Remains Elusive ([GAO/T-HEHS-97-165](#), June 26, 1997).

High-Risk Series: Medicare ([GAO/HR-97-10](#), Feb. 1997)

Medicare: HCFA's Contracting Authority for Processing Medicare Claims ([GAO/HEHS-94-171](#), Aug. 2, 1994).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending ([GAO/HEHS-94-42](#), Apr. 28, 1994).

Blue Cross And Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight ([GAO/HEHS-94-71](#), Apr. 13, 1994).

Medicare Secondary Payer Program: Identifying Beneficiaries with Other Insurance Coverage Is Difficult ([GAO/T-HRD-93-13](#), Apr. 2, 1993)

Medicare: Contractor Oversight and Funding Need Improvement ([GAO/T-HRD-92-32](#), May 21, 1992).

Medicare: Existing Contract Authority Can Provide for Effective Program Administration ([GAO/HRD-86-48](#), Apr. 22, 1986).

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